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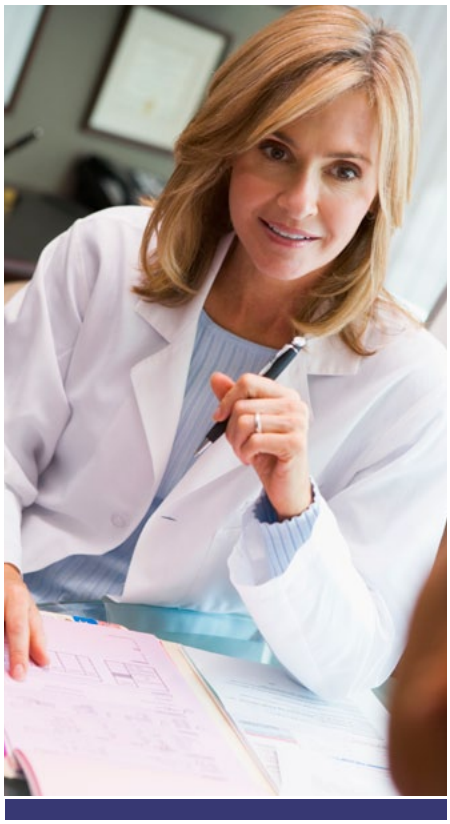
APRIL 3 2012

LTC LEADER

AANAC's Board and Expert Advisory Panel Working with CMS on Clarifications

By Jennifer Pettis, RN, BS, WCC, RAC-MT, Chair of the AANAC Expert Advisory Panel



The AANAC Expert Advisory Panel and members of the AANAC Board of Directors recently met, via conference call, with representatives the Centers for Medicare and Medicaid Services (CMS) to discuss concerns that members have communicated based on the recently released April 1, 2012 *RAI User's Manual* changes. Below are the issues which the Expert Advisory Panel raised with CMS:

- The inability to correct Assessment Reference Dates (ARDs) and Reasons for Assessments (RFAs) and resubmit the same assessment (and instead requiring the provider to complete a new assessment with the current date as the ARD);
- Unexpected discharges resulting in Change of Therapy Other Medicare Required Assessment (COT OMRAs) that should have been done because the assessment that stopped the seven day rolling window was not used for payment due to the discharge (for instance the 30 day was done on day 27—day seven of the COT observation period—but the patient went to the hospital on day 30 so the 30 day was never used for payment resulting in a COT that should have been done on the 27th); and
- The inability to submit MDSs done for reasons other than those completed for OBRA and PPS purposes.

Additionally, the Expert Advisory Panel requested clarifications as to whether or not to restart the Prospective Payment System (PPS) schedule when a resident with Medicare replacement plan converts to traditional Medicare. CMS reported clarity on this issue is forthcoming.

The AANAC Expert Advisory Panel appreciates the ability to discuss these concerns with CMS and will keep members apprised of any updates as soon as they are available.

As members are aware, CMS has issued further clarifications and the Expert Advisory Panel encourages members to, as CMS stressed in the clarification memo, take full advantage of the Encoding Period to avoid repercussions of the first two items that were discussed with CMS. The AANAC Expert Advisory Panel appreciates the ability to discuss these concerns with CMS and will keep members apprised of any updates as soon as they are available.

Courage doesn't always roar. **Sometimes courage is the quiet voice** *at the end of the day saying "I will try again tomorrow."*

—MARY ANNE RADMACHER

2011 MEMBERSHIP SATISFACTION SURVEY

AANAC Announces Results of 2011 Membership Satisfaction Survey

From the AANAC Board of Directors

The AANAC Board of Directors would like to thank the 1568 members (14%) who completed the recent Membership Survey. Having so many participants ensures that the results have high statistical reliability. With more than 12,000 members, this feedback helps us a great deal in serving your needs.

The Board and its Membership Linkage Committee are analyzing the survey results and will be addressing next steps throughout the year. At the April AANAC conference in Jacksonville, the Board is hosting a roundtable event to explore some of the key results further with the membership through a focus group style session. If you are interested in attending this session, please contact AANAC to add this session to your conference registration.

Summary of results

We asked numerous questions to identify the extent to which members agree with our current priorities, which guide AANAC's strategic planning. Below is a brief summary of the survey results.

We are happy to report that respondents indicated great satisfaction with the return on investment they receive as AANAC members with 78% of respondents agreeing that AANAC is their primary source of accurate, timely and affordable information and tools.

The single most important need you look to AANAC to fulfill is "Having skills/knowledge to conduct accurate and effective assessment" with 95% rating this very important.

- In rating overall satisfaction with AANAC membership, 89% reported being very satisfied or satisfied, 9% were neutral, and fewer than 2% reported dissatisfied.
- The single most important need you look to AANAC to fulfill is "Having skills/knowledge to conduct accurate and effective assessment" with 95% rating this very important.
- Members also ranked "Being knowledgeable about regulations/ public policy and their implications" as being important (96%).
- Perhaps the most significant issue rated as important (95%) but which few members (31%) believe to be currently the case is that "Long term care nursing is positively perceived within the nursing profession."

The survey process and results exemplified how important it is that we hear from you. Overall, the survey responses validate that current "Results Priorities" in our strategic planning are in sync with what you want, and you rate AANAC's performance extremely well!

We don't take that for granted. We ask that when we reach out to you in the future, whether through on-line surveys, forums, focus groups or other membership events - please DO connect with us to help us serve you.

Sincerely,

Carol Siem

Carol Siem, Board Chair

Carol A. Maher

Carol Maher, Chair,
Membership Linkage Committee

PPS ASSESSMENTS

Unscheduled PPS assessments: Management tips

Caralyn Davis, Staff Writer

Successful management of unscheduled PPS assessments is critical to avoiding default days and provider-liable days, says **Robin Hillier,** CPA, STNA, LNHA, RAC-MT, president of RLH Consulting in Columbus, Ohio. "That certainly makes administration a lot happier, and there's really less work for everyone because you're not playing catch-up."

AANAC master teachers offer the following suggestions to help MDS coordinators keep track of—or even avoid—end-of-therapy (EOT), change-of-therapy (COT), and start-of-therapy (SOT) Other Medicare Required Assessments (OMRAs):

Meet with therapy daily

There needs to be a daily meeting between the MDS coordinator and the rehab coordinator, says **Lisa Hohlbein,** RN, BS, RAC-MT, director of clinical reimbursement for LeaderStat in Columbus, Ohio. The meeting should include a review of treatment minutes and the number of days and disciplines. "The MDS coordinator and the rehab coordinator need to examine rehab patterns to look for any changes in intensity, planned or unplanned," she says. "They also need to review possibilities for potential discharge. All of these issues need to be reviewed because they have the potential to trigger an unscheduled assessment."

Schedule afternoon meetings

At many facilities, those rehab issues are discussed during daily PPS meetings, which typically are held in the early morning hours, notes Hillier. "Providers should either move their PPS meetings to mid-to-late afternoon, or they should have a quick follow-up meeting in mid-to-late afternoon with, at minimum, the MDS nurse and therapy. The problem is: When you have discussions in the morning, you plan based on what you think is going to happen for the day, not what actually happened."

Consider this example: Resident X is scheduled for therapy five days a week, Monday through Friday. If the facility has a PPS meeting on Friday morning, "they assume this resident is going to do the therapy that is scheduled during the day," Hillier points out. But for whatever reason, Resident X refuses therapy. That establishes day 1 of the three-day window for the EOT OMRA going into a two-day weekend.

"The MDS coordinator and the rehab coordinator need to examine rehab patterns to look for any changes in intensity, planned or unplanned," says Lisa Holbein.

"If the MDS nurse and the rehab director don't have another 10-minute meeting late in the day on Friday to say, 'Resident X didn't receive therapy as anticipated,' then the MDS nurse doesn't know

that the potential is there for the EOT OMRA, and the rehab director might not realize that the resident didn't get therapy, possibly missing an opportunity to schedule a therapist to pick up this resident on Saturday and make up the missed Friday therapy."

Late-afternoon meetings give providers greater flexibility, allowing them to identify residents who are potential candidates for unscheduled assessments as early as possible, says Hillier. "That's particularly important going into weekends and holidays."

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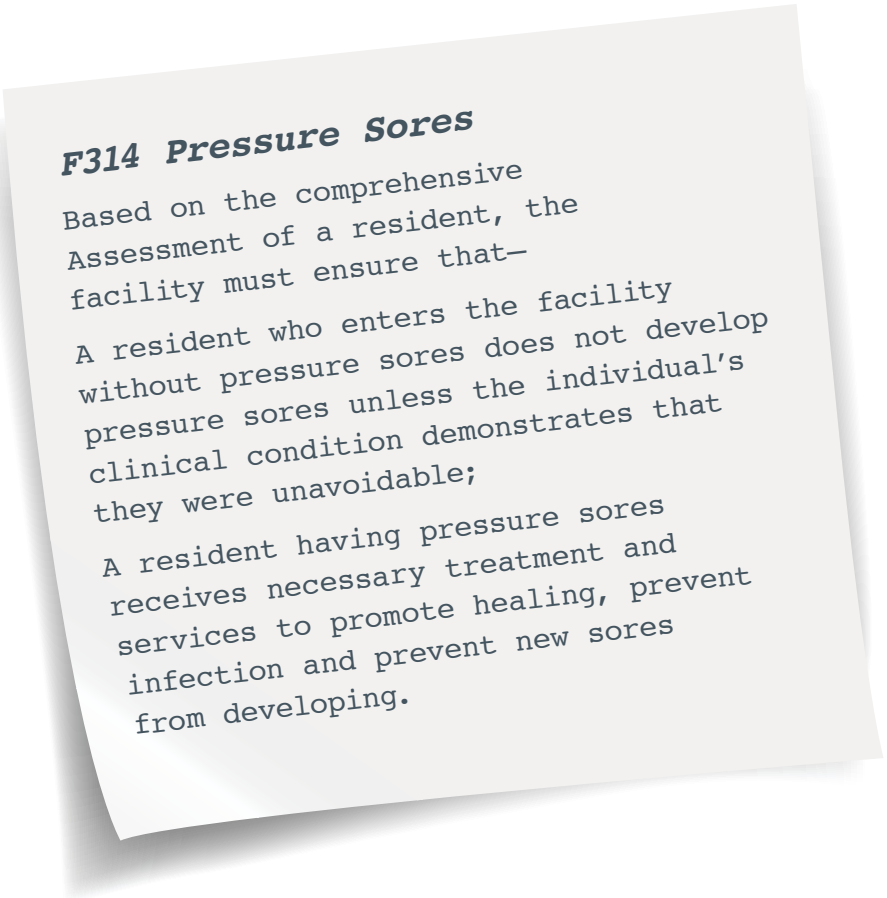
Pressure Ulcer Prevention and Management

Betty Frandsen, RN, NHA, MHA, C-NE



The intent of F314 is that a resident does not develop a pressure ulcer unless it is clinically unavoidable. Employees must understand what 'unavoidable' means, and be equipped to attain that standard of care. An unavoidable pressure ulcer is one that develops despite the following:

- The resident's clinical condition and pressure ulcer risk were thoroughly evaluated
- Interventions were defined and implemented consistent with resident needs, goals, and industry standards of practice
- Staff monitored and evaluated the impact of the identified interventions
- Approaches were revised as appropriate.

Conversely, an avoidable pressure ulcer develops because staff do not follow these expected steps. Education for nursing staff should include the following topics:

Assessment and Treatment

For each pressure ulcer, whether present on admission or developed afterward, determine the factors that influenced its development, the resident's potential for development of additional areas, or for deterioration of the pressure ulcer. A new pressure ulcer suggests that the adequacy of the prevention plan should be reevaluated. Include the following factors in the assessment of the ulcer: Type (pressure-related versus non-pressure-related), Stage, Characteristics, Monitoring progress toward healing and for potential complications, Presence of infection, Pain (assess, monitor, treat), Dressings and treatments.

Pressure Points and Tissue Tolerance

It is critical that clinical staff conduct regular skin assessments for each resident identified as at risk for development of pressure ulcers. Assessing resident's skin helps team members design individualized prevention strategies. Pressure ulcers typically are located over boney prominences, although they may develop where pressure impairs tissue circulation, such as pressure from positioning or from medical devices like oxygen tubing over ears and at the nares.

Nutrition or Hydration Deficits

Residents with nutritional or hydration deficits experience weight loss, which indicates a caloric imbalance. A resident with a pressure ulcer who continues

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Unscheduled PPS assessments, continued from page 3

Cultivate relationships

Regular meetings are important, but they are just the start, notes Hillier. "It goes without saying: It is increasingly important for MDS and therapy to have a good working relationship so that they communicate well—and frequently—throughout the day. The only way to truly stay on top of unscheduled assessments is for MDS and therapy to work together as a collaborative team every day, as opposed to finger pointing at each other. Then you will always have accurate, real-time information, which is going to keep you from getting surprises—and being late on assessments or finding out that you missed assessments."

Ramp up activity on Thursday, Friday

MDS nurses need to remain vigilant five days a week to manage unscheduled assessments, "but Thursday and Friday are the most important days to set up your weekend," advises Amy Franklin, RN, CDON, RAC-MT, director of RAI for Metron Integrated Health Systems in Grand Rapids, Mich. "Facilities have a maximum of two days to set the assessment reference date [ARD] after the ARD window for an unscheduled assessment has passed. So, for example, if you think you need a COT ARD where day 7 falls on Saturday or Sunday, enter it into your computer by Friday. You can always cancel the assessment on Monday, but you won't be late."

Pay attention to payment

Understanding the rules for unscheduled PPS assessments is not easy these days, given that CMS has already revised some of the instructions its officials issued during the MDS 3.0 National Conference in early March. (Look for the latest clarification memo here.) "However, MDS coordinators need to think about how the decisions they make impact payment," says Hohlbein. "They must have an awareness of ARDs and how scheduled assessments relate to unscheduled assessments. For example, they need to be able to determine whether it will benefit the facility to do a scheduled assessment with an ARD set before an unscheduled assessment."

Share monitoring duties

"There is a misconception among some MDS nurses that the responsibility for monitoring therapy for unscheduled assessments solely rests on the therapy department," says Hillier. The problem with that attitude is that the penalty lies on the SNF, not on the contract therapy company or the therapy department alone, if an unscheduled MDS is missed.

"So both the MDS department and the therapy department should be equally responsible for monitoring therapy throughout the week for residents who are on therapy

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Unscheduled PPS assessments, continued from page 5

caseloads," she advises. "If you are saying, 'That is therapy's job,' and somehow an EOT OMRA or a COT OMRA gets missed, it ultimately hurts the facility."

That monitoring can occur via "daily reporting by therapy at the end of the day, or the MDS nurse can have daily access to the therapy treatment logs," suggests Hillier. "But staying on top of EOT and COT OMRAs is such a critical thing that you really need two sets of eyes looking at it."

Try to set Sunday ARDs for scheduled PPS MDSs

"If you are going into a window for a scheduled PPS assessment, and you determine that you'll get the same RUG score no matter which ARD you pick (for example, day 13 and day 18 for the 14-day assessment will both generate the same RUG), you should consider using Sunday as the ARD," recommends Hillier.

When Sunday is the ARD for an MDS, "you are setting up your COT observation period going forward to be Monday through Sunday," she points out. "And that gives you the most flexibility to have residents hit their therapy level during that week. If they miss therapy one day from Monday to Friday, you have the option to provide therapy on Saturday or Sunday. However, if your Saturday or Sunday falls at the beginning of your COT observation period instead of at the end, and you are not normally scheduling the resident for therapy on the weekends, then you already missed the ability to deliver those two days. That makes it harder if something happens during the week, and the resident misses a day of therapy."

Use the time that CMS gives you

MDS coordinators are understandably under pressure to complete and submit MDSs at the end of the month because the facility can't bill Part A until the MDSs have been accepted into the QIES Assessment Submission and Processing (ASAP) system, acknowledges Hillier. "But aside from that end-of-the-month pressure, MDS nurses can obtain more flexibility simply by giving themselves a few more days between when they set the ARD and when they complete the MDS, sign off that it has been encoded, and submit it."

Hillier offers this example: On day 27 of the Part A stay, which is day 7 of the COT observation period, Resident Y potentially needs a COT OMRA because one therapy discipline has discharged her, resulting in a drop in therapy RUG category. The MDS nurse decides to avoid doing the COT OMRA by completing the 30-day PPS MDS with an ARD of day 27.

"In this situation, MDS nurses often will set the ARD for the 30-day MDS on day 27, complete that MDS on day 28, and

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Unscheduled PPS assessments, continued from page 6

submit it on day 28 or day 29," she points out. "The problem with that is: If this resident discharges unexpectedly on day 31, for example, and goes to the hospital, that 30-day MDS will not be used for payment. The new rules say that you need to have a COT OMRA, but that COT OMRA will now be late because the ARD can't be set any earlier than day 31, four days after day 7 of the COT observation period."

However, if the MDS nurse in this example had set the ARD for the 30-day MDS as day 27, but not been in such a hurry to submit that MDS, "when the resident went to the hospital on day 31 and you realized you needed a COT instead of the 30-day, you could just change the type of assessment because that MDS is not locked and submitted yet," advises Hillier. "That would save a lot of work having to inactivate the 30-day and do a new COT, which is going to be late."

MDS nurses have to set the ARD timely to be in compliance with Medicare

regulations, "but once you set the reference date timely, you have 14 days to complete the MDS, and then you have another 14 days to submit the MDS, the first seven of which is that encoding period where you could still make changes to it," she notes. "So many of the struggles with unscheduled assessments could be avoided if providers weren't quite so quick to get assessments completed and out the door as soon as they set that ARD."

Double-check assessment types

"With the new rules for inactivations, using an incorrect item set and not catching the error until after submission makes the facility subject to default payment days, at minimum, or even provider-liable days," says Franklin. "So it's a good idea to institute a simple, practical review of assessment types for both scheduled and unscheduled PPS assessments."

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Unscheduled PPS assessments, continued from page 7

At Franklin's facilities, MDS nurses use a paper 100-day PPS tracker. "They are going to do a double-check system," she explains. "They are going to make a check mark when they first set their ARD. Then two days later, they are going to make another check mark to make sure that that is the right assessment, that they're using the item set they really wanted. It's almost like doing a medication reconciliation."

Identify operational fixes

EOT and COT OMRAs often become necessary because of operational activities that the provider should consider doing differently, says Hillier. "For example, residents who are going to go out for a follow-up doctor's appointment on Monday are always potentially dangerous. They're often gone most of the day, and even if therapy is still in the building when they return, sometimes the residents won't participate in therapy because they are tired or in a bad mood. Many residents don't have therapy on Saturday or Sunday. Consequently, if they miss Monday, they will be in an EOT OMRA situation."

The solution: When a facility admits a resident with orders for a follow-up appointment scheduled for a Monday, the standard procedure should be for facility staff to try to change the appointment to a different day of the week where the resident missing therapy won't result in three consecutive days without therapy, suggests Hillier. "Furthermore, you should try to schedule follow-up appointments for the afternoon, which would allow you to deliver therapy to residents in the morning before they go out to the follow-up appointment."

Often, facilities that take the time "to adjust scheduling to set up the resident to be more successful hitting therapy targets will reduce the need to do unscheduled assessments," she points out.

Keep the IDT in the loop

"All the disciplines that participate in the MDS need to be armed with knowledge," says Hohlbein. "MDS coordinators should do some teaching so that the interdisciplinary team (IDT) members understand why we are scheduling unscheduled assessments and what potentially triggers them."

Don't forget billing

Whoever handles the facility's Part A billing needs to know the correct assessment indicator (AI) code and the number of days to be billed for each unscheduled assessment, says Hohlbein. "Those items should be reviewed by the MDS coordinator, the business office, and rehab before claims are submitted to make sure everyone has accurate information."

Q + A

After our annual survey everyone is so down. How do we avoid falling into the doldrums after the exit conference?

There are few events in the life of a nursing home that are more stressful than survey. Several approaches can be taken to promote resilience and to avoid or reduce the feelings you describe. Take time during and after survey to listen to your staff, and give them a chance to share their frustrations and survey experiences. A daily debriefing during survey helps foster a sense of oneness among team members and encourages them to draw strength from each other. Guide staff to separate their emotions from the survey experience. Acknowledge that they are working diligently every day to care for their residents. The survey process is an experience that everyone in the facility goes through. Talk about it and together resolve the negative feelings that could hinder progress. Apathy, detachment, and loss of interest after a difficult survey can prevent staff from getting back to normal routines. Acknowledge everyone's hard work and effort. Speak of the survey as a learning experience that will enhance care even more. Provide further training where it is needed. Encourage feedback from staff members to distinguish between deficient practices requiring further training and deficiencies related to other factors that may call for different solutions. Conduct root-cause analysis before developing an action plan so everyone understands the root of the issue. Re-look at the preparations made prior to survey and determine if there are areas that need more attention or education in advance

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BETTER TOGETHER—THE 2012 AANAC ANNUAL CONFERENCE

You've probably noticed that there are all sorts of new and exciting reasons why the 2012 AANAC Annual Conference in Jacksonville, Florida is going to be our best yet.

As the deadline for online registration gets closer, we wanted to give you at least 10 additional reasons why you simply can't afford to miss this event. Read on for our "Top Ten" reasons to attend.

JACKSONVILLE, FL
Hyatt Regency Riverfront

CONFERENCE
April 18 – 20

PRECONFERENCE
April 16 – 18

1. **A LONGER CONFERENCE** We expanded our conference to offer you more opportunities, choices and chances to get the vital updates and information you need.
2. **LEARNING TRACKS** New education tracks will help you focus on the information and skills that you need most.
3. **PRODUCT THEATERS** Get in-person demonstrations of the products and services that have been designed to ease your workload and make your job simpler.
4. **CLINICAL SESSIONS** Learn how to utilize your physical assessment capabilities to manage and support residents who suffer from skin wounds, chronic pain or dementia.
5. **THE 2012 AANAC AWARDS** Join us as we celebrate our celebrities in long-term care with a fantastic evening event complete with food, beverage and an entertaining reception to follow.
6. **INCREASED EXHIBIT HOURS** You'll have more time than ever to interact and learn about the newest trends and products right from the source. And maybe even win a prize during our "Exhibit Hall Scavenger Hunt."
7. **NETWORKING WITH THE BEST** Join forces with hundreds of other long-term care leaders, experts and enthusiasts by being a part of this conference. Spend time sharing success stories, and challenges and get insider information from others who have been through similar situations as yourself.
8. **A VIBRANT CITY** With a growing population, a strong economy, and diverse cultural and recreational opportunities, Jacksonville distinguishes itself as one of the nation's most dynamic and progressive cities.
9. **CONNECTED COMMUNITY** Meet other attendees before you even arrive on-site and start putting faces to all the friends you're going to make, through the AANAConnect online conference community.
10. **ONLY ONE CHANCE** Since we'll only have one conference this year, this is your best opportunity to join colleagues to ensure you're up-to-date on the most current regulatory updates, survey preparedness skills, quality control tactics and resident voice and choice issues.

SHARE THE FUN, THE KNOWLEDGE AND THE EXPERIENCE WITH OTHER LTC PROS.

REGISTER TODAY AT WWW.AANAC.ORG/2012CONFERENCE

AANAC 2012 UPCOMING WORKSHOPS

TRAINING PARTNER	MASTER TEACHER	DATES	CITY/STATE
2012 AANAC ANNUAL CONFERENCE			
AANAC RAC-CT Certification	Robin L. Hillier	Apr 16 – 18	Jacksonville, FL
AANAC Medicare University	Judy Wilhide Brandt	Apr 16 – 18	Jacksonville, FL
AANAC C-NE Certification	Jennifer Pettis	Apr 16 – 18	Jacksonville, FL
AANAC RAC-CT Recertification	Rena R. Shephard	Apr 18	Jacksonville, FL
RAC-CT CERTIFICATION WORKSHOPS			
LeaderStat	Lisa Hohlbein	Apr 10 – 12	Dallas, TX
Pathway Health Services, Inc.	Cynthia Perrault	Apr 10 – 12	Westmont, IL
LeadingAge Iowa	Deb Myhre	Apr 10 – 12	Des Moines, IA
Harmony Healthcare International	Jennifer Pettis	Apr 10 – 12	New York, NY
LeadingAge NY (formerly NYAHSA)	Sandy Biggi	May 1 – 3	Rochester, NY
Harmony Healthcare International	Jennifer Pettis	May 1 – 3	Windsor, VT
LeadingAge New York (formerly NYAHSA)	Sandy Biggi	May 1 – 3	Rochester, NY
Pathway Health Services, Inc.	Cynthia Perrault	May 8 – 10	Green Bay, WI
LeaderStat	Lisa Hohlbein	May 8 – 10	Detroit, MI
LeaderStat	Lisa Hohlbein	May 15 – 17	Silver Spring, MD
Judy Wilhide MDS Consulting	Judy Wilhide Brandt	May 15 – 17	King of Prussia, PA
KHCA—Kansas Health Care Association	Becky LaBarge	May 16 – 18	Topeka, KS
Hill Educational Services, Inc.	Carol Hill	May 21 – 23	Mobile, AL
Pathway Health Services, Inc.	Cynthia Perrault	May 22 – 24	Spokane, WA
Judy Wilhide MDS Consulting	Judy Wilhide Brandt	May 22 – 24	Boston, MA
Life Services Network	Ronald Orth	May 22 – 24	Springfield, IL
Duran Consulting Services	Sandy Biggi	June 4 – 6	Portsmouth, NH
Pathway Health Services, Inc.	Judi Kulus	June 5 – 7	Eden Prairie, MN
MEDICARE UNIVERSITY WORKSHOPS			
Harmony Healthcare International	Jennifer Pettis	June 4 – 6	Charleston, SC
Judy Wilhide MDS Consulting	Judy Wilhide Brandt	June 5 – 7	Virginia Beach, VA

The workshop schedule is subject to change and is updated regularly. To see a full AANAC Training Partner workshop schedule, visit aanac.org/workshops

What's new in AANAConnect

Thousands of "peer-shared" LTC resources at your fingertips

What are resource libraries?

Resource libraries are where documents and files uploaded by members are kept. Each community has one, and each library is searchable. You can also search across all of the libraries on AANAConnect. Files and documents can get into the library in one of two ways:

1. Each time an attachment is shared in a discussion group it is automatically uploaded into the group's library.
2. Files can be uploaded directly to the library of your choice.

You can access a community's resource library in several ways:

3. Click on the link/paper clip icon in an email you receive from a discussion group.
4. Click on the link named "Files" for the community you wish to access on the "View Community Discussions" page.
5. Go to "Communities" in the top navigation, and choose "View Libraries." From there, select "All Libraries" to browse or "Search Library" to look for specific files.
6. From the "Communities" page, locate the community you want and click on the number located to the right of the "Book" icon.

Save and store the resources that you need

Library entries can contain several files. To view and download an attachment, click on its name under "Attachment(s)". If you want all of the files, click on the library entry name and then the "Download all" link found at the bottom of the "Attachment(s)" section.

Help point out the "good stuff" to others

Each library entry has a five-star rating system, similar to amazon.com and other sites where you can flag things you like. By rating a document, you can help others judge the quality of the information contained in the file(s). Commenting allows you to add additional information—if a document was helpful and why, if it contains incorrect information, etc.

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Active Discussions this week on AANAConnect:

LTC Network:

Thread Subject: Hypodermaclysis

Posted by: Cheryl Druce

I recently had a discussion with my team about exploring IV use in the facility. We currently do not offer IV management. The DON and NP are suggesting hypodermaclysis instead. I have never seen this done, and I don't think it would benefit us for reimbursement. Is this still in use? What are the risks of clysis vs IV therapy? How well do elderly clients respond to the treatment?

When there are a variety of treatment options, it's always good to know what's available. This is especially true when one option could have a noticeable impact on coding the MDS 3.0 or your facility reimbursement. Hear what other members and an AANAC expert had to say by clicking on the thread subject above.

MDS Connection:

Thread Subject: Overnight

Posted by: Rose Pauly

Resident is going out at 9:15 Monday morning for a procedure at the hospital. They plan on keeping her overnight for observation. Am I correct that if she is not back by 9:15 on Tuesday we will have to do the interviews etc. as this is a planned discharge?

Sometimes it's better to be safe than sorry—especially when it comes to missing interviews. How would you handle this situation? Click on the thread subject to see how you compare with those that answered this member question.

What You Need to Know

Check out these latest updates from the "Need to Know" section of the AANAC homepage and find the information you need to get the job done right.

UPDATE: CMS to Make 3 Corrections to New SNF PPS Clarifications Memo

jRAVEN 1.1.4 Free MDS Software Update

MDS 3.0 Item List for RUG-IV

Reimbursement Tip

CMS has clarified in the March 2012 SNF PPS Clarifications Memo that both an early and a late COT reset the COT calendar so that the next COT evaluation period would be 7 days after the ARD of the early or late COT.

Jennifer Pettis, RN, BS, WCC, RAC-MT
Director of Program Development

Treatment of Members Policy

AANAC has posted the Treatment of Members Policy on the website. If you need to access it, please click here.

Get Answers Now

When you need answers fast, the best place to start is AANAConnect. We have thousands of member questions that have already been answered by our experts who moderate the communities 24/7. Just type your topic into the search box to see the discussions, tools and peer-submitted resources that may be just what you're looking for.

Pressure Ulcer Prevention and Management, continued from page 4

to lose weight needs increased calories or correction of other conditions that are the root cause. When instituting a nutritional care plan, address the following aspects: severity of nutritional compromise, weight loss rate, loss of appetite, the individual's prognosis, the expected clinical course, and resident wishes and advance directives.

Interventions

When developing an individualized skin plan, use the comprehensive assessment to provide the basis for defining approaches that address residents at risk for or who already have a pressure ulcer. A resident determined to be at high risk has significant implications for preventative and treatment strategies that must be communicated to all levels of nursing staff.

Monitoring

Nursing staff must remain alert for potential skin changes, and at least daily evaluate and document identified changes. The interdisciplinary team should develop a care plan that includes prevention and management of skin care interventions with measurable goals. An evaluation should be conducted at least weekly to include skin color, moisture, temperature, integrity, and turgor.

Moisture Exposure

Exposure to urine and feces irritates skin and makes it susceptible to breakdown. Skin irritation from this exposure makes skin more susceptible to damage from friction and shear during repositioning.

Support Surfaces and Pressure Redistribution

Pressure redistribution incorporates the concepts of both pressure reduction and pressure relief. Match a device's potential therapeutic benefit with the resident's specific situation. The effectiveness of any support surface or device is based on the potential benefit for the resident's specific situation. One product does not meet everyone's needs.

Repositioning

Assessment of the resident's skin integrity and achievement of pressure reduction or redistribution should guide the development of a repositioning plan. Consider those at risk of friction or shearing during repositioning, as lifting devices may be needed.

For detailed information on pressure ulcer prevention, staging, and management, access F314 Pressure Ulcers by visiting http://www.cms.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf.

What's New in AANAConnect, continued from page 12

Want to share something of your own?

You can upload a file directly to a library, or you can attach it to a message. To upload a file directly, go to "View Libraries" under "Communities" in the top navigation and click on "Add a New Entry" from the submenu. Follow the steps on the page, and be sure to choose the correct library from the dropdown box labeled "Library."

To attach a file to a message you are posting, click the "Attach" button beneath the message box on the "Post a Message" page. Follow the steps on the form, click "Finish," and send your message.

Q + A, continued from page 9

of the survey team's arrival. Adequate preparation will reduce the potential negative impact of survey. AANAC offers valuable resources to help nurse leaders prepare for either the traditional or the Quality Indicator Survey. Survey Preparedness teaches the reader to be ready for survey every day of the year. This and other helpful resources are available at www.aanac.org.

Betty Frandsen, RN, NHA, MHA, C-NE *(bmacfran@gmail.com)*

A new resident was admitted on Part A from home on March 16. She had been discharged to home from a rehab hospital on February 15, 2012. We were told she qualifies for Part A even though she didn't have a new 3-day qualifying hospital stay because she is within her 30-day window. I think she was admitted to us on her 31st day, which would be outside the 30-day window. When she was discharged to home on February 15—does that count as day 1 or 0?

Actually, it is the day after discharge that is day 1. From the Medicare Benefit Policy manual: "In determining the 30-day transfer period, the day of discharge from the hospital is not counted in the 30 days."

Ronald A. Orth, RN, NHA, CPC, RAC-MT *(raorth@clinicalreimbursement.com)*

I am finding there is a lot of confusion surrounding what is meant by a Local Contact Agency for Q0600. Some feel this is the normal protocol we follow for a discharge for a short-term stay when we refer to a home health agency or other support services. Others view it as a referral to services that the resident/family can access once discharged for additional supports. Please explain.

Each state has arranged for a specific agency or agencies to act as Local Contact Agencies to provide information about supports and services in the community. The LCA provides information about community living options and available supports and services beyond what facility generally provides, such as locating housing, transportation, employment, social engagement opportunities, home modification, setting up a household, community inclusion planning. Usually, it is not necessary to call in the LCA when the discharge is what might be called routine, but even with a routine discharge for a short-term resident, a referral may be made to the LCA if a complication occurs that may be able to be resolved with the more advanced services provided by the LCA. See the instructions for completing section Q in chapter 3 of the RAI User's Manual

Rena R. Shephard, MHA, RN, RAC-MT, C-NE *(RRS2000@aol.com)*

We have a COT OMRA that resulted in RUG level LC2. But according to our calculations, it should have been an RMB. I don't know what happened, and I want to make sure our billing department can bill for the appropriate RUG and we get billed the appropriate RUG from the therapy company.

Here are some specifics: ST-135 individual minutes, 4 days of treatment; OT-105 individual minutes, 3 days of treatment; Both disciplines continued through the ARD

If your facility is "urban" and not "rural," then LC2 pays more than RMB. You are seeing an example of index maximization, where the software selects the RUG that pays the most. You must continue to follow the COT observation process in this case. But, it does appear that your software calculated the RUG correctly. You will know for sure when you transmit the MDS. If the federal data base does not report a RUG error, then the RUG on the MDS is correctly reported.

Carol Maher, RN-BC, RAC-CT *(cmaher0121@earthlink.net)*

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AANAC | 400 S. Colorado Blvd., Suite 600 | Denver, Colorado 80246 | *Phone* 800.768.1880 | *Fax* 303.758.3588